

CERTIFICATE OF DEATH

8242

Reg. Dist. No. 105

1. PLACE OF DEATH

COUNTY

Charles

MARYLAND

CITY (If outside corporate limits, write RURAL
OR end give nearest town)

TOWN Rural - Waldorf

LENGTH OF STAY
(In this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESSlife
Berry Road.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Rural - Waldorf

STREET
ADDRESS

(If rural give location)

Berry Road

3. NAME OF
DECEASED
(Type or Print)

(First) JUANITA (Middle) S. (Last) BERRY

4. DATE
(Month) (Day)
OF DEATH Aug. 2. 1956

5. SEX

Female white

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, No, unk.)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

20. AUTOPSY?
YES NO

21. IMMEDIATE CAUSE (A)

22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

23. DATE OF OPERATION

24. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

25. TIME OF INJURY (Month) (Day) (Year) (Hour)

26. MAJOR FINDINGS OF OPERATION

27. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)28. WHERE DID INJURY OCCUR? (City or town)
(County) (State)

29. HOW DID INJURY OCCUR?

30. SIGNATURE

31. DATE SIGNED

32. BURIAL, CREMATION,
REMOVAL (SPECIFY)

33. DATE THEREOF

34. NAME OF CEMETERY OR CREMATORIUM

35. LOCATION (City, town, or county)

36. ADDRESS (Street, city, town, state)

37. ADDRESS

38. REC'D BY REGISTRAR

39. REGISTRAR'S SIGNATURE

40. FUNERAL DIRECTOR'S SIGNATURE

41. ADDRESS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

ST. THOMAS-NEW YORK STATE MAIL

STATE OF NEW YORK

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DEPARTMENT OF STATE

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08219

8243 CERTIFICATE OF DEATH

Reg. Dist. No. 100

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN)	Charles La Plata	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital		STREET ADDRESS Bryans Road (If rural give location)	
3. NAME OF DECEASED (Type or Print)		(First) Albert	(Middle) Marvin
		(Last) Betts	4. DATE (Month) (Day) (Year) OF DEATH August 10, 1956
5. SEX Male	6. COLOR OR RACE col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 25, 1901
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE last birthday 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
13. FATHER'S NAME William Thomas Betts		11. BIRTHPLACE (State or foreign country) Virginia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		14. MOTHER'S MAIDEN NAME Mary Eliza Evans	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mary Morton, Bryans Road, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO <u>8/10-16</u> ONSET AND DEATH DISEASES OR CONDITIONS, IF ANY, (B) <u>Hypertension</u> ?? GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-10</u> , 19 <u>56</u> , to <u>8-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-10</u> , 19 <u>56</u> , and that death occurred at <u>12 noon</u> M. from the causes and on the date stated above. SIGNATURE <u>E.J. Gedelen</u> DATE SIGNED <u>8-10-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial & Removal</u>		DATE THEREOF <u>8/12/56</u>	NAME OF CEMETERY OR CREMATORIAL <u>New Bethel</u>
24. REC'D BY REGISTRAR DATE <u>AUG 13 1956</u>		REGISTRAR'S SIGNATURE <u>J. J. Polley</u>	LOCATION (City, town, or county) <u>Altom, Va.</u>
		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archont Funeral Home, La Plata, Md.</u>	ADDRESS

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BUREAU V. S.
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Aug 13 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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8244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newport		c. LENGTH OF STAY IN 1b RURAL and give nearest town Newport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WASHINGTON First PATTERSON Middle LOST BOWLING		4. DATE OF DEATH Month Day Year AUG 27 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 FEB 1869
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wallace Bowling		14. MOTHER'S MAIDEN NAME Ellen Dolman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Walter W. Bowling		Address Nwepoort, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest		INTERVAL BETWEEN ONSET AND DEATH instant	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. 450.8 (b) arterosclerosis		10 yrs	
DUE TO (c) age			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 17, 1956 , to 8-27 1956 , that I last saw the deceased alive on 8-27 1956 , and that death occurred at 300 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE JM Johnson		ADDRESS (Street, city or town, state) La Plata DATE SIGNED 8-27 '56	
PHYSICIAN'S NAME (Type) E.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 30 1956	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dentsville		22d. LOCATION (City, town, or county) (State) DENTSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE The Huntt Funeral Home		24a. REC'D BY REGISTRAR DATE SEP 4 1956	
		24b. REGISTRAR'S SIGNATURE Wm. F. Wills Possey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. FROM THE STATE OF NEW YORK
TO THE STATE OF CALIFORNIA

BUREAU V. S.

SEP 4 1956

REGELIV E

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M
A34

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8245 CERTIFICATE OF DEATH

08221

Reg. Dist. No. 100

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Charles La Plata	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Charles STREET ADDRESS (If rural give location)	Charles Indian Head 4 Jackson Rd.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital					
3. NAME OF DECEASED (First) CAROL (Middle) CATHERINE (Last) CARPENTER (Type or Print)			4. DATE OF DEATH AUG 9 1956		
S. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 5, 1903	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR Months Deyrs Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Nichols			14. MOTHER'S MAIDEN NAME Lillie Moon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Charles B. Carpenter Indian Head, Md.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 782.4 IMMEDIATE CAUSE (A) Cardiac failure ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Obesity INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. el work		21a. INJURY OCCURRED While Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-7-1956, to 8-9-56, that I last saw the deceased alive on 8-8-1956, and that death occurred at 7:45 AM, from the causes and on the date stated above. SIGNATURE					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-12-56	NAME OF CEMETERY OR CREMATORIAL Pisgah Cem (M.E.)	ADDRESS (Street, city, town, state) LA PLATA MD 8-9-56 LOCATION (City, town, or county) Pisgah, Md.	
24. REC'D BY REGISTRAR AUG 15 1956 DATE		REGISTRAR'S SIGNATURE Julia Pacey	DATE SIGNED The Huntt Funeral Home Waldorf, Md.		
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					

BUREAU V. 3

AUG 15 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118222
Reg. Dist. No. 106

~~TO DEPUTY MEDICAL EXAMINER:~~ This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

~~TO FUNERAL DIRECTOR:~~ Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
<i>CHARLES Co.</i>		b. COUNTY <i>Prince Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>COBB ISLAND</i>		c. LENGTH OF STAY IN 1b <i>6 MOS.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MARLOW HEIGHTS</i>	
d. STREET ADDRESS <i>5943 28-Ave</i>		d. STREET ADDRESS <i>5943 28-Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MELVIN W.</i>		First <i>M.</i>	Middle <i>CHEVILLE</i>
4. DATE OF DEATH <i>8-4-56</i>		Month <i>8</i>	Day <i>4</i>
5. SEX <i>M</i>		5. COLOR OR RACE <i>W</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. B. DATE OF BIRTH <i>9-8-23</i>		8. AGE (In years birthday) <i>32 yrs.</i>	9. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <i>Instrument Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NAVAL RESEARCH</i>	11. BIRTHPLACE (State or foreign country) <i>Rhodone Neb.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>EDWARD B. CHEVILLE</i>	
14. MOTHER'S MAIDEN NAME <i>INEZ C. BLANKENSHIP</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	
16. SOCIAL SECURITY NO. <i>579-20-1182</i>		17. INFORMANT <i>Mrs Naomi M. CHEVILLE</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fell From Boat</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8-4-56</i>	
DUE TO <i>850x</i>		(b)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>fall from boat</i>		DUE TO <i>Fell From Boat</i>	
C. DUE TO <i>850x</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>g. m.</i> <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>CEDAR HILL</i>
20f. (City or town) <i>CHESTER</i>		(County) <i>Chester</i>	
(State) <i>MD</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. EDELEN M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <i>8-6-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-9-56</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR HILL</i>		22d. LOCATION (City, town, or county) <i>SUITLAND MD</i>	
(State) <i>MD</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Chambers B. Wash. D.C.</i>		ADDRESS <i>Wash. D.C.</i>	
24a. REC'D BY REGISTRAR <i>AUG 8 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. Odey Price</i>	
VS. A15ME(S) SM 9/55		DATE	

RECEIVED
BUREAU V. S.
Aug 8 1956

REGISTRATION CERTIFICATE OF MAIL-SWIMMING
STATE OF MICHIGAN

RECEIVED
BUREAU V. S.
Aug 8 1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

118223

8247 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY	Charles	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)
TOWN	La Plata	(en-route)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Physicians Memorial Hospital	

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	Maryland	COUNTY	Charles
CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN	Cobb Island	(If rural give location)	
STREET ADDRESS			

3. NAME OF
DECEASED
(Type or Print)

John P Denham

(First)	(Middle)	(Last)
Male	White	Married
6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
	Married	8-18-1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
Electro-Vater		54 yrs.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	12. CITIZEN OF WHAT COUNTRY
<i>Albert V. Denham</i>	<i>Florence Sanford</i>	<i>U.S.A.</i>

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) *No* 16. SOCIAL SECURITY NO. *577-40-0109*

17. INFORMANT & ADDRESS

Helen V. Denham Cobb Island Md

18. MEDICAL CERTIFICATION

420.1 IMMEDIATE CAUSE (A) *Ischaemic Occlusion*
 ANTECEDENT CAUSE(S) DUE TO
 DISEASES OR CONDITIONS, IF ANY, (B)
 GIVING RISE TO THE ABOVE CAUSE
 STATING UNDERLYING CAUSE LAST. DUE TO
 (C)

INTERVAL BETWEEN
ONSET AND DEATH*8-27-56*II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21a. INJURY OCCURRED
 M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *8-27-56*, to *8-27-56*, 19, that I last saw the deceased alive on *8-27-56*, 19, and that death occurred at *12:30 P.M.* from the causes and on the date stated above.
 SIGNATURE *J. E. Pedersen* ADDRESS (Street, city, town, state) *La Plata Md* DATE SIGNED *8-27-56*

23. BURIAL, CREMATION,
REMOVAL (SPECIFY) DATE THEREOF NAME OF CEMETERY OR CREMATOR Y LOCATION (City, town or county) (State)

Burial 8-30-56 St. Lincoln Cem. Washington D.C.

24. REC'D BY REGISTRAR DATE REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

AUG 29 1956

Julia Posey W.W. Chambers 517-1154 DE.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

B6

VS AISC 1-55 10W

BY PROMISES WHICH ARE TRUSTED STATE GUARANTEED

STATE OF SOUTH DAKOTA

RECEIVED

RECORDED IN THE OFFICE OF THE SECRETARY OF STATE

AT THE CITY OF SIOUX CITY, SOUTH DAKOTA

ON THE TWENTY-THREE DAY OF JUNE, ONE THOUSAND NINETEEN FIFTY-SIX

FOR THE USE OF THE STATE OF SOUTH DAKOTA

IN THE MATTER OF THE APPOINTMENT OF A COMMISSIONER

TO THE STATE OF SOUTH DAKOTA

FOR THE PURPOSE OF CONDUCTING AN ELECTION

ON THE TWENTY-THREE DAY OF JUNE, ONE THOUSAND NINETEEN FIFTY-SIX

FOR THE USE OF THE STATE OF SOUTH DAKOTA

IN THE MATTER OF THE APPOINTMENT OF A COMMISSIONER

TO THE STATE OF SOUTH DAKOTA

FOR THE PURPOSE OF CONDUCTING AN ELECTION

ON THE TWENTY-THREE DAY OF JUNE, ONE THOUSAND NINETEEN FIFTY-SIX

FOR THE USE OF THE STATE OF SOUTH DAKOTA

IN THE MATTER OF THE APPOINTMENT OF A COMMISSIONER

TO THE STATE OF SOUTH DAKOTA

FOR THE PURPOSE OF CONDUCTING AN ELECTION

ON THE TWENTY-THREE DAY OF JUNE, ONE THOUSAND NINETEEN FIFTY-SIX

FOR THE USE OF THE STATE OF SOUTH DAKOTA

IN THE MATTER OF THE APPOINTMENT OF A COMMISSIONER

TO THE STATE OF SOUTH DAKOTA

FOR THE PURPOSE OF CONDUCTING AN ELECTION

ON THE TWENTY-THREE DAY OF JUNE, ONE THOUSAND NINETEEN FIFTY-SIX

FOR THE USE OF THE STATE OF SOUTH DAKOTA

IN THE MATTER OF THE APPOINTMENT OF A COMMISSIONER

TO THE STATE OF SOUTH DAKOTA

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ON THE TWENTY-THREE DAY OF JUNE, ONE THOUSAND NINETEEN FIFTY-SIX

FOR THE USE OF THE STATE OF SOUTH DAKOTA

STATE OF SOUTH DAKOTA

APPOINTMENT

COMMISSIONER

ELECTION

SOUTH DAKOTA

BUREAU X. S.

AUG 29 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C L-5510A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8248

CERTIFICATE OF DEATH

18224

Reg. Dist. No. 100

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)		
TOWN LA PLATA	LENGTH OF STAY (in this place) 6 DAYS	MD Indian Head	Riverside 34 Carroll Dr 8-4941		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physicians Mem. Hospt</i>					
3. NAME OF DECEASED (First) <i>Henry</i> (Middle) <i>W.</i> (Last) <i>GARDNER</i> (Type or Print)				4. DATE OF DEATH AUG 4 1956	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>DEC 22, 1885</i>	9. AGE last birthday 70 yrs.	10. UNDER 1 YEAR Months <i>0</i> Dey <i>0</i> Hours <i>0</i> Min. <i>0</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <i>Tool Maker</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own shop & C.</i>	11. BIRTHPLACE (State or foreign country) <i>Rhode Island</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Henry J. Gardner</i>			14. MOTHER'S MAIDEN NAME <i>Abby Pickerton</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>035-10-7919</i>		17. INFORMANT & ADDRESS <i>HOSPITAL Records</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <i>Cardio Renal Disease</i>					
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension</i>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arterio Sclerosis General</i>					
None					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19e. DATE OF OPERATION					
19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug 15-19 1956</i> to <i>Aug 23 to 8-4-56</i>, 19....., that I last saw the deceased alive on <i>Aug 4 1956</i>, and that death occurred at <i>12227</i>, from the causes and on the date stated above.					
SIGNATURE <i>James E. Gardner M.D.</i> DATE SIGNED <i>Aug 8-4-56</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>8-8-56</i>	NAME OF CEMETERY OR CREMATORIAL <i>Lawnterset Cem.</i>	LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE <i>Aug 7 1956</i>		REGISTRAR'S SIGNATURE <i>Julia F. Posey</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>W.W. Chambers Co 517-110 ST S.E. JM Robinson 9352</i>		

BY PROMISE TO THE UNITED STATES GOVERNMENT

STATE OF TEXAS

BUREAU V. S.

AUG 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118225

8249

CERTIFICATE OF DEATH

Reg. Dist. No.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the physician or attending physician may be retained by the hospital or attending physician, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY <i>CHARLES</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LAPATAN</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FRANCIS J.</i>		First	Middle
4. DATE OF DEATH <i>HIGDON</i>		Month	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-27-1873</i>
9. AGE (In years last birthday) <i>83</i>		10. UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS. Days <i>10</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Naval Powder Factory</i>	
11. BIRTHPLACE (State or foreign country) <i>Charles County</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Higdon</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Franklin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Wilson W. Wright</i>		Address <i>Accokeek, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Collapse</i> DUE TO <i>157X</i> INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Carcinoma of pancreas</i> (c) <i>1 year</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1945</i> to <i>Aug 1956</i> that I last saw the deceased alive on <i>17 Aug 1956</i> , and that death occurred at <i>9310 La Plaza Rd</i> , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. O. Wooddy MD</i>		ADDRESS (Street, city or town, state) <i>La Plaza Rd</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-21-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Marbury Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Marbury, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Aug 21 1956</i>	
		24b. REGISTRAR'S SIGNATURE <i>Julia Possey</i>	

BUREAU V. S.

AUG 21 1956

REFUGEE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A
A34

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8250

CERTIFICATE OF DEATH

118226

100

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	MARYLAND <i>Length of stay (in this place)</i>	STATE <i>Maryland</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hilltop</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	TOWN <i>Ridge Memorial Hosp</i>	OR TOWN <i>Hilltop</i>	STREET ADDRESS <i>(If rural give location)</i>
3. NAME OF DECEASED (First) <i>William</i> (Middle) <i>N.</i> (Last) <i>Johnson</i>		4. DATE OF DEATH (Month) <i>8</i> (Day) <i>30</i> (Year) <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY <i>Married</i>	8. DATE OF BIRTH <i>May 15 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
13. FATHER'S NAME <i>William Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Mason</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT & ADDRESS <i>Mac Wellitt Clinton Md</i>		18. MEDICAL CERTIFICATION <i>Cerebral hemorrhage</i> <i>Hepat enceph</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>8-8-56</i>			
IMMEDIATE CAUSE (A) <i>Cerebral hemorrhage</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hepat enceph</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i></i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i></i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i></i>	
21c. WHERE DID INJURY OCCUR? (City or town) <i></i> (County) <i></i> (State) <i></i>		21d. TIME OF INJURY (Month) <i>8</i> (Day) <i>30</i> (Year) <i>1956</i> 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i></i>			
22. I hereby certify that I attended the deceased from <i>8-8-56</i> to <i>8-30-56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>8-29-56</i> , 19 <i>56</i> , and that death occurred at <i>1/2</i> M, from the causes and on the date stated above. SIGNATURE <i>J. E. Edens</i> ADDRESS <i>La Plata Md</i> DATE SIGNED <i>8-30-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept 1, 1956</i>	NAME OF CEMETERY OR CREMATORIUM <i>Old Durham</i>
24. RECEIVED BY REGISTRAR <i>SEP 5 1956</i>		REGISTRAR'S SIGNATURE <i>Mrs. J. Wellitt Powers</i>	LOCATION (City, town, or county) <i>Levistide Md</i> (State) <i></i>
DATE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i> ADDRESS <i>Levistide Md</i>	

BUREAU

SEP 5 1956

REFUGEE VILLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be rejoined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8251

CERTIFICATE OF DEATH

18227
Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE	
3. NAME OF DECEASED (Type or print) PATTIE		First ELIZABETH	Middle KERSHAW
4. DATE OF DEATH Lost 8/18/1869		Month AUGUST	Day Year 27 1956
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/1869
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JEREMIAH DUDLEY	
14. MOTHER'S MAIDEN NAME JENNIE ALVEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. -----		17. INFORMANT LUCILLE K. NORRIS - LEONARDTOWN, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 422.1		(b)	
DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		(c)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1956 , to Aug 27, 1956 , that I last saw the deceased alive on Aug 19, 1956 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville		DATE SIGNED 8/27/56	
ACTUAL SIGNATURE J. ROY GUYTHIER		M.D.	
PHYSICIAN'S NAME (Type) J. ROY GUYTHIER, M.D.		MECHANICSVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/29/56	22c. NAME OF CEMETERY OR CREMATORIUM OLDFIELD CEMETERY	22d. LOCATION (City, town, or county) (State) HUGHESVILLE, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Robinson		ADDRESS LEONARDTOWN, Md.	24a. REC'D BY REGISTRAR DATE 8/28/56
			24b. REGISTRAR'S SIGNATURE John D. Haas

WYOMING STATE DEPARTMENT OF HEALTH - SANITATION

BUREAU Y.

AUG 29 1956

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118228¹⁰⁰
Reg. Dist. No. 282

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>CHARLES CO</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>ST MARYS</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HUGHESVILLE</i>		c. LENGTH OF STAY IN 1b <i>Highway #5</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>U.S. NAVY POTOMAC RIVER</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Highway #5</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>DONALD Eugene MARTIN</i>		First <i>D</i>	Middle <i>E</i>	Last <i>MARTIN</i>	4. DATE OF DEATH <i>8</i>	Month <i>5</i>	Year <i>1956</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-29-33</i>		9. AGE (In years last birthday) <i>22 yrs.</i>	10. IF UNDER 1YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. NAVY</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>CALIFORNIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JOHN EDWIN MARTIN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES ✓ 11851 to 85-8</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>U.S. Navy Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CRUSHED Chest</i>		DUE TO <i>823X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8-5-56</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i>		DUE TO <i>(c)</i>		<i>Auto accident - driver</i>		8-5-56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Driver of automobile which left Highway and overturned</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>1215 Aug 5 1956</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>STREET</i>		20f. (City or town) (County) (State) <i>HUGHESVILLE Charles MD.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>8-6-56</i>			
EXAMINER'S NAME (Type) <i>F.T. Edelen</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transportation</i>		22b. DATE THEREOF <i>8/7/56</i>		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State) <i>Kansas City, Missouri</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.B. Johnson</i>		ADDRESS <i>Leonardtown, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>8/7/56</i>		24b. REGISTRAR'S SIGNATURE <i>Glenn D. Shaver / J. G. Shaver</i>	

MANHATTAN STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED

AUG 8 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118229

8253

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Charles Co</i>		a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Welcome</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Welcome</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>EDNA</i>		First <i>M</i>	Middle <i>A</i>
4. DATE OF DEATH		Month <i>8</i>	Day <i>14</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>June 14 1901</i>		9. AGE (In years lost birthday) <i>55</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>W</i>		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <i>md</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Hall</i>		14. MOTHER'S MAIDEN NAME <i>Rosie Duckett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Brooks Matthews Welcome</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vasculair Accident</i> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c) <i>Nephritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8-11-56</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Baltimore</i> (County) <i>Maryland</i> (State) <i>Md</i>
21. I certify that I attended the deceased from _____, 19 <i>54</i> , to <i>8-14</i> , 19 <i>56</i> , that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>8/18/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St Ignatius</i>
22d. LOCATION (City, town, or county) <i>Hilltop Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rechardine La Plata</i>		24a. REC'D BY REGISTRAR DATE <i>8/16/56</i>	24b. REGISTRAR'S SIGNATURE <i>Julia H. Rosey</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 DEPARTMENT OF THE TREASURY STATE CAPITAL

AUG 22 1956

REFUGEE COUNCIL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10231

Reg. Dist. No. 100

10830 Items 13, 14 File #0205 10-29-56 et

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata, Md.		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians' Memorial Hospital		d. STREET ADDRESS 17 N St., S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Richard	Middle Mitchell	Last
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1902
9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days 22	12. Year 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Cervical Vertebrae -Cord Severance 3 days			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Automobile Accident			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto involved in accident	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8-19-56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
		20f. (City or town) Hughesville, Charles, Md.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED	
EXAMINER'S NAME (Type) E. J. Edelen, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-27-56		22b. DATE THEREOF 8-27-56	22c. NAME OF CEMETERY OR CREMATORIAL Broadlawn
22d. LOCATION (City, town, or county) Hughesville, Charles, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frazee's Funeral Home</i>		ADDRESS 389-R S St	
24a. REC'D BY REGISTRAR DATE Oct. 24, 1956		24b. REGISTRAR'S SIGNATURE <i>Julia Posey</i>	

THE UNIVERSITY OF TEXAS
DEPARTMENT OF POLITICAL SCIENCE
RECEIVED EXAMINER'S CERTIFICATE OF DEBT

BUREAU V.

JCT 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8257

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG202 9-1-56 et.

68233

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington DC</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy Wmn Hosp</i>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mitchell</i>		First <i>RICHARD</i>	Middle Last 4. DATE OF DEATH <i>8 22 1956</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan 15 1902</i>		9. AGE (In Years last birthday) <i>54</i>	10. IF UNDER 1 YEAR Months <i>8</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Concrete worker</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>N.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>825-10-0000</i>		17. INFORMANT <i>Ethel M Mitchell Washington DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>825X</i>		DUE TO <i>Fract. Conv. Vertebra Cord Severe</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO <i>Auto accident</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>8-19-56</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Blow to head</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>8 19 1956</i>	
		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>At home</i>	
20f. (City or town) <i>Hughes Chas Rd.</i>		(County) <i>Charles Co.</i>	
(State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>F. J. Edelen</i>		DATE SIGNED <i>8-23-56</i>	
EXAMINER'S NAME (Type) <i>F. J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/27/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		22d. LOCATION (City, town, or county) (State) <i>Washington DC</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home La Plata</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE <i>Julia H. Hayes 8/27/56</i>	
24b. REGISTRAR'S SIGNATURE <i>Julia H. Hayes</i>			

BUREAU X

AUG 29 1956

REGELY E

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118230

Item 20 Film G202 9-12-56 ems

8254 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		b. COUNTY Charles	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS # 8 Coudon Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle E	Last PEARSON
4. DATE OF DEATH	Month 8	Day 11	Year 1956
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 4, 1950
9. AGE (In years last birthday) 5 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Charles Co
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Raymond E Pearson	14. MOTHER'S MAIDEN NAME Grace E. Weaver		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT Raymond Pearson Indian Head Md	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9140 DUE TO ELECTROCUTION INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (b) _____			
(a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Electrocuted on home-made fence			
20c. TIME OF INJURY Month, Day, Year Hour 7:00 p.m. 8/11/56 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard (Home)
20f. (City or town) Indian		(County) Charles	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin	DATE SIGNED 8-12-56		
EXAMINER'S NAME (Type) PAUL F. GUERIN	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/14/56	22c. NAME OF CEMETERY OR CREMATORIAL St Pauls Cemetery	22d. LOCATION (City, town, or county) Waldorf (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Circhart Inc	ADDRESS La Plata Md	24a. REC'D BY REGISTRAR Julia W. Pasay	24b. REGISTRAR'S SIGNATURE Julia W. Pasay
VS. A15ME(S) 5M 9/55			

STATE DEPARTMENT OF MINE - TERRITORY OF
EDUCATIONAL EXAMINERS CHIEF OFFICER

BUREAU V.

AUG 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18231

8255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

105

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains, Md.		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Walter	Middle Peterson	4. DATE OF DEATH 8 30 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1892
9. AGE (In years less birthday 64 yrs.)		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Minn		12. CITIZEN OF WHAT COUNTRY? None	
13. FATHER'S NAME Knutte Peterson		14. MOTHER'S MAIDEN NAME Emma Yener	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Ernest H. Peterson		Address Baltimore, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) _____ Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 11/2 hrs			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William J. Kurz, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DATE SIGNED			
EXAMINER'S NAME (Type) William J. Kurz, M.D.			
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 3, 1956	22c. NAME OF CEMETERY OR CREMATORIAL St. Paul Cemetery	22d. LOCATION (City, town, or county) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md		ADDRESS RECD BY REGISTRAR SEP 5 1956	24b. REGISTRAR'S SIGNATURE Mr L Monroe

BUREAU Y.

SEP 5 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 18232

8256

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 105

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b <i>life</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Vera</i>	Middle <i>Mae</i>	Last <i>Proctor</i>			
4. DATE OF DEATH	Month 8	Day 31	Year 1957			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-18-55</i>			
9. AGE (in years last birthday) yr. <i>80</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Lester Proctor</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Queen</i>	Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Lester Proctor Waldorf Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5710</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
			INTERVAL BETWEEN ONSET AND DEATH <i>8-30-31-57</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month, Day, Year <i>Sept 1, 1957</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>St. Peters</i>	20f. (City or town) <i>Waldorf</i>	(County) <i>Maryland</i>	(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>E. J. ELEEN</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>8-31-57</i>		
EXAMINER'S NAME (Type) <i>E. J. ELEEN</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 1, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peters</i>	22d. LOCATION (City, town, or county) <i>Waldorf</i>	(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Burnett Funeral Home Waldorf</i>	ADDRESS <i>1001 St. Peters Rd. Waldorf Md</i>	24. REG. NO. <i>1001</i>	25. REG. DATE <i>Sept 1, 1957</i>	26. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>		

WEDGWOOD EXHIBITION CERTIFICATE OF AUTHORITY

BUREAU Y.

SEP 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8258

CERTIFICATE OF DEATH

118234-00
282

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN. (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE		c. LENGTH OF STAY IN 1b 11 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE			
3. NAME OF DECEASED (Type or print) LUCY		First ELMORE	Middle RIDGELL		
4. DATE OF DEATH AUGUST 22 1956	Month Month	Day Day	Year Year		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 19, 1874		
9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 82	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
13. FATHER'S NAME AUSTIN RIDGELL	14. MOTHER'S MAIDEN NAME SUSAN R. HAMMETT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. -----	17. INFORMANT Mrs. RUTH BRAGG - HUGHESVILLE, Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
Carcinoma (Basal cell) Face			INTERVAL BETWEEN ONSET AND DEATH 10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. n. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MECHANICSVILLE, MARYLAND	20f. (City or town) MECHANICSVILLE, MARYLAND	(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from June 1, 1956 to Aug 22, 1956 that I last saw the deceased alive on Aug 22, 1956 and that death accrued at MECHANICSVILLE, MARYLAND from the causes and on the date stated above. ADDRESS (Street, city or town, State) MECHANICSVILLE, MARYLAND					
ACTUAL SIGNATURE J. ROY GUYTHER, M.D.	DATE SIGNED Aug 23/56				
PHYSICIAN'S NAME (Type) J. ROY GUYTHER, M.D.	MECHANICSVILLE, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/25/56	22c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAELS CEMETERY	22d. LOCATION (City, town, or county) RIDGE, MARYLAND	(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE G. B. Johnson	ADDRESS LEONARDTOWN, Md.	24a. REC'D BY REGISTRAR 8/28/56	24b. REGISTRAR'S SIGNATURE Glenda A. Howard		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

400016 X VS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Items 3,13 Film 0204 9-19-56 et										118235			
1. PLACE OF DEATH a. COUNTY <i>Charles</i>					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Md</i>					Reg. Dist. No. <i>100</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i>					c. LENGTH OF STAY IN lb <i>3 months</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>MARY</i>	Middle <i>Elizabeth</i>	Last <i>Roberts</i>	DATE OF DEATH <i>5-1-56</i>		Month <i>5</i>	Day <i>5</i>	Year <i>1956</i>				
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>5-1-56</i>		9. AGE (In years last birthday) yrs. <i>3</i>		IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>4</i>	Hours <i>8</i>	Min. <i>00</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			11. BIRTHPLACE (State or foreign country) <i>MD.</i>			12. CITIZEN OF WHAT COUNTRY? <i>MD.</i>				
13. FATHER'S NAME <i>James Robertson</i>			14. MOTHER'S MAIDEN NAME <i>Christine Young</i>			Address <i>Bryantown, Maryland</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT- <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH <i>8-4-56</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>49IX</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>													
DUE TO <i>(c)</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <i>8-5-56</i>											
EXAMINER'S NAME (Type) <i>E. J. Edelen M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 9 1956</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Marys</i>		22d. LOCATION (City, town, or county) <i>Bryantown</i>		(State) <i>Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>		ADDRESS <i>1000 16th St. N.W.</i>		24a. REC'D BY REGISTRAR <i>J. E. Posey</i>		24b. REGISTRAR'S SIGNATURE <i>J. E. Posey</i>							
DATE <i>AUG 7 1956</i>													

STATE OF HAWAII
DEPARTMENT OF HEALTH

EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y.

AUG 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18236
Reg. Dist. No.

105

8260

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN lb Unk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Robert Smith		First	Middle	Last	DATE OF DEATH	Month	Day	Year
4. SEX M	5. COLOR OR RACE W	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH 7-20-1872	8. AGE (In years from birthday) 84 yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days	11. IF UNDER 24 HRS. Hours	12. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) St Mary's County			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Swann			14. MOTHER'S MAIDEN NAME Georgeanna Mattingly			Address Wicomico, Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none			17. INFORMANT Mrs Robert P. Bowling		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gen Art Sclerosis DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 8-17-52								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>F. J. Edelen</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <i>8-18-52</i>						
EXAMINER'S NAME (Type) <i>F. J. Edelen</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-56		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Rest Cem.		22d. LOCATION (City, town, or county) La Plata, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home Waldorf, Md.				ADDRESS 24a. REC'D BY REGISTRAR AUG 21 1956 24b. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i>				

RECEIVED - MEDICAL DOCUMENTS SECTION - DEPARTMENT OF DEFENSE

RECEIVED - MEDICAL DOCUMENTS SECTION - DEPARTMENT OF DEFENSE

BUREAU V. S.

AUG 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8261

CERTIFICATE OF DEATH

108237
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	c. LENGTH OF STAY IN lb Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William (Willie)	First J.	Middle Thomas	4. DATE OF DEATH Aug. 11, 1956
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1883
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -	
10c. BIRTHPLACE (State or foreign country) La Plata, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Madison I. Thomas		14. MOTHER'S MAIDEN NAME Theresa Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT William A. Thomas		3054 Vista St. N.E. Washington, D.C. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Stomach		INTERVAL BETWEEN ONSET AND DEATH 1954	
151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-11, 1956, pronounced dead, that I last saw the deceased alive on , 19 , and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE E. J. Edelen, M.D.		DATE SIGNED 8-11-56	
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) 8-11-56		22b. DATE THEREOF 8-11-56	
22c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH		22d. LOCATION (City, town, or county) Pamplin Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D. BY REGISTRAR DATE 8/15/56	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~burial~~ papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2501

BUREAU V.
RECEIVED
AUG 17 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG202 9-1-56 et

CERTIFICATE OF DEATH

18238
Reg. Dist. No. 705

8262

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b UNK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>none</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf Rural</i>	
3. NAME OF DECEASED (Type or print) GRACE		First JOHANA	Middle ULLMANN
4. DATE OF DEATH August 22, 1956	Last ULLMANN	Month August	Day 22
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30-13-1888
9. AGE (In years at birthday) 68	yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anton Winklez		14. MOTHER'S MAIDEN NAME Emily Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Barbara Duffy		Address Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Ventricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Myocardial Infarction</i> (c) <i>Atherosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-20</u> , 19 <u>56</u> , to <u>6-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-22</u> , 19 <u>56</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Richard H. Dobson</i> M.D. Physician's Name (Type) <i>Richard H. Dobson</i> ADDRESS <i>Berwyn, Md.</i> <i>Berwyn, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-25-56	22c. NAME OF CEMETERY OR CREMATORIAL St Joseph's Cem.	22d. LOCATION (City, town, or county) Pomfret, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE The Huntt Funeral Home Waldorf, Md.		24a. REC'D BY REGISTRAR DATE 8/27/56	
		24b. REGISTRAR'S SIGNATURE M. L. Monroe	

81 ЗНОМТАС-НІЖАН РО ВІЧНІЙ РАДІОСТАНЦІЇ ОЛІВІЯМ

GUDEAU V. S.

9561

REGEV EDO
1956

8263 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88239

Reg. Dist. No.

106

Item 18: G202 9-5-56

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FRANCIS W. WEDDING		First	Middle		
4. DATE OF DEATH August 7, 1956		Month	Day		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-2-32		
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing		11. BIRTHPLACE (State or foreign country) Md.			
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph Wedding		14. MOTHER'S MAIDEN NAME Maude Wynn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. MMXX Korea 217 28 8725			
17. INFORMANT Joseph Wedding		Address Indian Head, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC BRONCHITIS DUE TO EARLY BRONCHO PNEUMONIA					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FATTY INFILTRATION OF LIVER					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>William Lovitt</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8-11-56 22c. NAME OF CEMETERY OR CREMATORIUM Mt Rest 22d. LOCATION (City, town, or county) La Plata, Md (State)			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR Aug 15 1956	24b. REGISTRAR'S SIGNATURE <i>Mrs. Adey Price</i>

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